LOUISIANA
Department of
HEALTH and
HOSPITALS

UNISYS

ENROLLMENT PACKET FOR THE LOUISIANA MEDICAL ASSISTANCE PROGRAM (Louisiana Medicaid Program)

Pharmacy

Emergency Enrollment due to Hurricane Katrina

(Enrollment Packet is subject to change without notice)

PT 26
Revised 08/05

unisys

To Whom It May Concern:

Enclosed is the enrollment packet for the Louisiana Medical Assistance Program (also known as the Louisiana Medicaid program) you requested. It contains a participation agreement, enrollment data and forms with instructions. You should carefully review these materials, including all instructions, before completing the necessary forms.

The Medicaid Program requires all providers to be state certified for claims to be processed. After completing the enrollment packet materials, please return all forms to:

Unisys Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159

Please be sure to include any and all Medicare provider numbers you want linked to the Medicaid provider number. If you have applied for a Medicare provider number but have not received the number(s), please submit the number(s) to Provider Enrollment at the above address upon receipt. Claims will not automatically cross electronically from Medicare to Medicaid unless these provider numbers are linked in our system.

If you have provided services to a Louisiana Medicaid recipient prior to the date you receive State certification, you must send a letter with your enrollment packet stating the earliest date that services were provided to a Louisiana Medicaid recipient. It will be necessary that all eligibility requirements are met at the time of service for Unisys to authorize retroactive eligibility. Any claims submitted prior to receipt of this letter must be resubmitted once the enrollment process is completed.

The Unisys Provider Enrollment Unit will take necessary steps to certify you as a provider and participant in the Louisiana Medical Assistance Program. Upon Certification, you will be notified of your Medicaid provider number that must be used for billing. Also, Unisys Provider Relations will forward a provider manual to you. If manual is not received within two (2) weeks of notification, please notify Provider Relations at (800) 473-2783 or (225) 924-5040.

If you have any questions concerning the completion of this enrollment packet, please contact the Provider Enrollment Unit at the above address or at (225) 237-3370. Thank you for your cooperation.

Sincerely,

Provider Enrollment Unit
Louisiana Medicaid Project

Pharmacy
CHECKLIST OF FORMS TO BE SUBMITTED

The following checklist shows all documents that must be submitted to the Unisys Provider Enrollment Unit in order to enroll in the Louisiana Medicaid Program as a Pharmacy provider:

Completed	Document Name
☐	1. Completed Louisiana Medicaid PE-50 Enrollment Form* (Read instructions carefully before completing these form)
☐	2. Completed PE-50 Addendum – Provider Agreement*
☐	3. Copy of printed document received from IRS showing Employer Identification Number (EIN) and official name as recorded on IRS records. **W-9 forms are not accepted**
☐	4. Completed Louisiana Medicaid – Provider Enrolment Ownership Summary Report. (This form is generated once all information is submitted online at www.lamedicaid.com under the Provider Enrollment link.)
☐	5. Completed Medicaid Direct Deposit (EFT) Authorization Agremeent*
☐	6. Copy of Voided Check – for account to which you wish to have your funds electronically deposited. **Deposit slips are not accepted**
☐	7. To submit electronic claims, a Completed EMC contract and Power of Attorney (if applicable) must accompany this application. Refer to Basic Enrollment Packet for details.

*Forms are included in the Basic Enrollment Packet

PLEASE USE THIS CHECKLIST TO ENSURE THAT ALL REQUIRED ITEMS ARE SUBMITTED WITH YOUR APPLICATION FOR ENROLLMENT.

ATTACHED FORMS MUST BE SUBMITTED AS ORIGINALS WITH ORIGINAL SIGNATURES (NO STAMPED SIGNATURES OR INITIALS).

Please submit all required documentation to:
Unisys Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159

M. J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

David W. Hood
SECRETARY

RE: Dispensing Cost Survey

Dear Pharmacy Provider:

All pharmacy providers requesting enrollment in the Louisiana Medicaid Program are required to complete the enclosed Dispensing Cost Survey.

As a new provider, or when changing ownership, you are only required to complete Part I and the Declaration by owner and/or preparer. The survey must be returned to the Bureau of Health Services Financing and approved prior to your pharmacy and receiving a provider number.

Should you need assistance in completing the cost survey, please feel free to call 225-342-9768. Your assistance and cooperation are appreciated in completing this mandatory participation requirement.

Sincerely,

M. J. Terrebonne, P.D.
Pharmacy Benefits Management Program

MJT/gs

DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING

Pharmacy Benefits Management
P.O. Box 91030
Baton Rouge, LA 70821
225/342-9768

PURPOSE

The purpose of this survey is to determine the cost of dispensing prescriptions in the State of Louisiana. Complete these forms using your most recent fiscal year ending.

WHO MUST FILE

All pharmacies that are Louisiana Medicaid providers must file this cost report.

Retail Pharmacies

This survey is designed so that most retail pharmacies can complete it by using their most recent federal income tax return. **Remember to round all amounts to the nearest dollar or whole number.**

Retail Chain Pharmacies

Expenses incurred by chain pharmacies such as administration, central operating, or other general expenses should be allocated to individual units. **Warehousing expenses must be either separately identified or included in cost of goods sold.** Methods of allocation must be reasonable and conform to generally accepted accounting practices. Please explain any allocation procedures used.

PART 1 – PHARMACY ATTRIBUTES

The information gathered from your answers to these questions will be analyzed to determine its relationship to your cost of dispensing a prescription. You may have to provide estimates for some answers; please estimate as carefully and accurately as possible.

Louisiana Medicaid Pharmacy Cost Report

Louisiana Department of Health and Hospitals
Bureau of Health Services Financing
Pharmacy Benefits Management
P.O. Box 91030
Baton Rouge, LA 70821
225-342-9768

ROUND ALL AMOUNTS TO NEAREST DOLLAR OR WHOLE NUMBER.

Name of Pharmacy ( ) Phone

Address City State Zip Code

DECLARATION BY OWNER AND PREPARER

I declare that I have examined this cost report including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, complete, and in agreement with the related Books or Federal Income Tax Return, except as explained in the Reconciliation. Declaration of preparer (other than owner) is based on all information of which preparer has any knowledge.

Owner's Signature Print/Type Name Title/Position Date

Preparer's Signature (other than owner) Title/Position Date

Preparer's Street Address City and State Zip Code Phone

PART I – PHARMACY ATTRIBUTES

(a) Type of Ownership:

1. ☐ Individual 2. ☐ Corporation 3. ☐ Partnership
4. ☐ Not-for-Profit 5. ☐ Institutional 6. ☐ Other (specify)_____

(b) Location:

1. ☐ Medical Office Building 2. ☐ Shopping Center
3. ☐ Separate or downtown 4. ☐ Other (specify)_____

(c) Ownership Affiliation:

1. ☐ Independent (1 – 14 units) 2. ☐ Chain (15 or more units)

(d) Do you dispense in anything other than traditional packaging to long-term care facilities?

1. ☐ Full 24-hour unit dose
2. ☐ Modified unit dose (Bingo cards)
3. ☐ Both
4. ☐ No unit dose

What is the approximate percent of prescriptions dispensed in unit dose packaging?
_____

(e) If you checked box 1, 2, or 3 of (d), what percent of the unit dose prescription packaging is:
1. Purchased from manufacturers _____
2. Prepared in the pharmacy _____

(f) Check if you own your building ☐

(g) What percent of total prescriptions filled are delivered? _____
What percent of Medicaid prescriptions filled are delivered? _____

(h) Are you presently providing home IV or infusion therapies and/or enteral nutrition therapy?
☐ Yes ☐ No
If yes, what is the amount of your sales for those Rx's? _____

(i) How many hours per week is your pharmacy open? _____

(j) What is the approximate percentage of the total number of prescriptions dispensed that is third-party Rx, including Medicaid Rx? _____

(k) How many years has a pharmacy operated at this location?_____

(l) What is the approximate percent of your prescriptions dispensed to nursing home residents?
_____

(m) Does your pharmacy dispense parenteral enteral products through a franchise with another entity? ☐ Yes ☐ No
If yes, does this other entity maintain the pharmacy inventory? ☐ Yes ☐ No

(n) Please estimate the number of generic prescriptions dispensed during the fiscal year:_____

(o) What was the value of the prescription drug inventory at the end of the fiscal year? _____

(p) Do you contract with an inventory management company? ☐ Yes ☐ No
If yes, please report the amount of your drug inventory management fees during the fiscal year of the cost report _____

(q) Do you provide 24-hour emergency services for pharmaceuticals? ☐ Yes ☐ No

(r) Please report the amount of your point of sale transaction fees expenses during the fiscal year of the cost report _____

(s) Do your pharmacists provide cognitive (consultation) services? ☐ Yes ☐ No
If yes, please estimate the number of minutes per day spent by pharmacists providing cognitive services in excess of the cognitive services required by OBRA 90 _____

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
1201 CAPITOL ACCESS ROAD, P.O. BOX 629
BATON ROUGE, LOUISIANA 70821-0629
PHONE (225) 342-9500
FAX (225) 342-5568

Provider Name: _____ **Provider Number:** _____

POINT-OF-SALE ANNUAL RE-CERTIFICATION

I certify that all Point of Sale claims are rendered by a legally qualified person, that the charge is within the Department's prescription package policy and that the payment has not been previously received. I have read and understand all published regulations, Prescription Drug Services Manual and Provider Updates concerning pharmaceutical payments and agree that all point of sale services adhere to those regulations. I also agree to keep such records as are necessary or required to disclose fully the extent of Point-of-Sale services provided to individuals under the State's Title XIX plan and to furnish all information regarding any payments claimed for providing such Point of Sale services as the state agency or the Medicaid Fraud Control Unit may request for five (5) years from the date of services.

I understand that payment and satisfaction of the claims will be from federal and state funds and that any false or misleading claim statements, documents or concealment of material fact, may be prosecuted under applicable federal and state laws.

Provider Name: _____
Provider Number:

Authorized representative (print): _____

(If the provider is a corporation or partnership, a statement from the Corporation's Board of Directors certifying the above authorized representative must be attached to the Point-of-Sale Certification and Enrollment Amendment)

_____
(Title)

_____
Authorized representative (signature):

_____
Signature of Pharmacist in Charge License Number

Date: _____

Mail completed Form to:

Bureau of Health Services Financing
Pharmacy Benefits Management
P. O. Box 91030 BIN #24
Baton Rouge, LA 70821

Provider Name: _____ **Provider Number:** _____

STATE OF LOUISIANA
MEDICAID PHARMACY POINT-OF-SALE AGREEMENT

This Pharmacy Point of Sale Agreement (hereinafter Agreement), made and entered into this _____ day of _____ 20_____, by and between the Louisiana Department of Health and Hospitals (Hereinafter Agency), acting in its own right as the Agency responsible for administering the Medicaid Assistance Program (Title XIX) In and by (hereinafter Provider).

In consideration of the mutual promises and covenants contained herein and other good and valuable consideration, the pharmacy agrees to provide said services in accordance with the following terms and conditions.

1. This Agreement is in addition to the Provider Enrollment Application between the Agency and Provider, including, but not limited to the right of the Agency or its representatives to perform audit functions or the requirement that the Provider maintain the original prescription on file.

2. Provider shall submit to the Agency, through the fiscal agent (hereinafter Agent), for Louisiana Medicaid, via a Point of sale (POS) device, claims for prescriptions dispensed to Louisiana Medicaid recipients.

3. The Provider shall safeguard the Medicaid program against abuse in its utilization of claims entry through the POS system.

4. The Provider shall correctly enter the claims data, monitor the data and certify that the data entered is correct.

5. The Provider shall reverse any claim which is adjudicated (submitted for payment) and then not dispensed to a Medicaid recipient.

6. The Provider shall allow the Agency access to claims data and assure that transmission of claims data is restricted to authorized personnel so as to preclude erroneous payment by the Agent resulting from carelessness or fraud.

7. The Provider shall allow the Director of the Agency or any of its designees and representatives of the Office of the Medicaid Fraud Control Unit to review and copy all records.

8. The Provider shall abide by all Federal and State statutes, rules, regulations and manuals and provider updates governing the Louisiana Medicaid Program and those conditions as set out in the State of Louisiana, Department of Health and Hospitals Medicaid Provider Agreement entered into previously.

9. The Provider agrees to charge no more for Medicaid services than is charged to the general public.

PROVIDER: _____

Print of Type Name Signature/Title

_____

Address

_____

Phone Number

Provider Name: _____ **Provider Number:** _____

PHARMACY PROVIDER ANNUAL RECERTIFICATION AMENDMENT

WHEN REVIEWING INFORMATION, PLEASE NOTE IF THERE ARE ANY CHANGES BELOW

LA Pharmacy Permit #:_____ (Please attach current copy of permit) Medicare Provider #:_____

PHYSICAL ADDRESS **MAILING ADDRESS**

E-Mail Address:_____

Phone:_____ Fax:_____

Electronic Switch Vendor ☐ Web MD ☐ NDC ☐ QS-1 ☐ Other _____

Software Vendor _____

Pharmacy Services Provided (Check all that apply):

☐ Retail ☐ 24 Hours Pharmacy

☐ IV Therapy ☐ IV Therapy Exclusively

☐ Nursing Home ☐ Nursing Home Exclusively ☐ Nursing Home/Group Home/ICF/MR

(please list the names of nursing homes/group home/ICF/MR serviced below and attach separate document if necessary)

Nursing Home/Group Home/ICF/MR Name and Address	Approximate Number of Recipients	Consultant PD

Provider Name: _____ **Provider Number: _____**

PHARMACY PROVIDER ANNUAL RECERTIFICATION AMENDMENT

Pharmacy Indicator (Check only one please):
(Louisiana defines a chain as 15 or more Medicaid enrolled pharmacies under common ownership in Louisiana)

☐ Independent Pharmacy ☐ Chain Pharmacy

INDEPENDENT OWNER INFORMATION	**CHAIN INFORMATION (IF APPLICABLE) (Fill out if checked above)**	
Owner Name(s):	Corporate Name:	
Owner Name(s):		
Address:	Address:	
City State: Zip:	City State: Zip:	
	Financial Contact	Phone

EMPLOYEE INFORMATION

Pharmacist In Charge	License Number	Disease State Certification and Date of Certification (if applicable)
Pharmacists	License Number	Disease State Certification and Date of Certification (if applicable)
Pharmacy Technicians	Certification Number	

Provider Name: _____ **Provider Number:** _____

PHARMACY PROVIDER ANNUAL RECERTIFICATION AMENDMENT

In the past twelve (12) months has there been a change in ownership for your pharmacy?

_____ Yes (Attach Disclosure of Ownership Information)

_____ No

Please list ownership interest in any other pharmacies (attach separate document if necessary)

Owner Name	Pharmacy Name	Pharmacy Address	Medicaid Provider Number (if applicable)

Is the Medicaid Provider Number listed above a 340 B contracted pharmacy? _____ Yes _____No

If you are a 340 B pharmacy, does your pharmacy carve out Medicaid recipients? _____ Yes _____No

Is this pharmacy provider associated with the sole distribution of a drug? _____ Yes _____No

(Example: Prolastin, Cystagon, Flolan, etc.)

If YES, please list the drugs: (attach additional pages if necessary): _____

Please list the wholesaler(s) you use:

Wholesaler 1:_____

Wholesaler 2:_____

Wholesaler 3_____

Does your pharmacy use Bar code technology to scan the drugs being dispensed/billed? _____ Yes _____No

What are your pharmacy store hours?_____

Does your pharmacy provide a delivery services? _____ Yes _____No

Does your pharmacy provide drugs via mail order if requested by the recipient? _____ Yes _____No

Approximately what percentage of your total business if Medicaid? _____%

Remittance Advice Reviewer Name	Remittance Advice Reviewer Title	Remittance Advice Reviewer Phone

EMPLOYEE INFORMATION

FOR PHARMACY USE ONLY

	NAME	STATE BOARD CERTIFICATE NO.	DATE OF ISSUE	RENEWAL DATE
STORE OWNER				
PHARMACIST				
PHARMACIST				
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